Green Mountain Care Board
144 State Street
Montpelier, VT 05601
November 11, 2019

Re: Northwestern Medical Center Emergency Department renovation
CON Docket No. GMCB-003-19con

To the Green Mountain Care Board:

We provide this written comment as individuals who have direct lived experience with psychiatric hospitalization and who have been involved in a deeply detailed and collaborative team process of helping in the architectural design work for the new psychiatric area of the emergency department, and inpatient units, in anticipation of a CON application from Central Vermont Medical Center. The organizational and additional individual co-signers of this letter represent psychiatric survivors and consumers, or advocates for them, who are aware of our work and are endorsing our input.

We are very concerned about aspects of the plans that have been presented by Northwestern Medical Center for a psychiatric area in its renovations for its emergency department. We recognize that the Department of Mental Health has been asked for input, and the plans might still change, so these comments address the plans as of the current date. We appreciated seeing the NMC responses to the GMCB questions about the segmented unit, which are helpful in clarifying points of discussion.

Although we agree fully with the need for a specialized area whenever there are specialized clinical needs, we do not think the design meets the goals or vision for how emergency room mental health care should be provided in Vermont. As such, it does not meet criterion number 9 for a Certificate of Need ("The project will support equal access to appropriate mental health care that meets standards of quality, access, and affordability equivalent to other components of health care as part of an integrated, holistic system of care, as appropriate.") We note that this *new legislative criteria was added after Rutland Regional Medical Center designed and built the psychiatric area in its emergency room*, which is particularly important given NMC's response that its new unit is appropriately designed because it "mimics" the design at RRMC. To the extent that the CON application implies that its plan as proposed is required by CMS when it states that the type of area in the design will "bring us into true compliance with CMS expectations regarding the environment of care," it is not accurate, nor does CMS have a "best practice" design standard.

There are two primary concerns:

Lack of Appropriate Patient Space

First, the development of a specialized space should be focused on meeting the particular clinical needs of the patients to be served there. We support the need for a calming space that is set off from other ED areas that allows for greater personal support and contact when that is the overarching component of the clinical emergency, and when medical needs can be adequately addressed in that area. While a significant percentage of individuals meeting those criteria will be patients in psychiatric crisis, others should also have access to such space, and it should not be limited to, or designated as, a space segregating mental health patients. (We note that the term "behavioral health" is often recognized as stigmatizing and demeaning when incorrectly used solely to designate mental health and substance use disorder.)

Many patients in this category may be facing a longer stay in the ED than other patients, so a vital component of such specialized spaces is the ability for mobile patients to have areas outside of their rooms to socialize or engage in activities. This is also crucial in order to allow for engagement with peer supports and family members. The presence of and space for personal advocates is often critical, and the patient rooms do not accommodate this. **Access to visits by peers or support persons designated by the individual is mandated by state statute for individuals being held for admission under the custody of the Commissioner. 18 VSA § 7508.** This is why having a small lounge or gathering area is becoming the standard of care for areas designed to address emotional crises. NMC's reference to the occasional circumstances when a segregated patient may be able to "walk in [the] hallway" shows recognition of the need, yet disregard of ensuring availability. Other hospitals in the state that are currently designing renovations or new EDs are including lounge areas for that purpose. Pacing a hallway – even on the occasions it may be available – does not address that patient need. NMC is proposing to spend in excess of $7 million on a renovation that has as one of its significant justifications meeting the needs of mental health patients, without including an essential design component for meeting those needs. This omission from the NMC plan is a serious gap in meeting quality standards and in providing equivalent standards of quality as for other health conditions.

Violation of Right to Voluntary and Dignified Care

Second, we are concerned that the plans appear to contemplate at least two, and potentially all four, of the patient rooms being locked off from the rest of the emergency department. Although the NMC responses indicate an intent to use the locked capability unit based on "patient-specific behaviors and risks," it makes no distinction between patients who are seeking out medical care and the small number of patients who are under the care and custody of the Commissioner of the Department of Mental Health.

All persons have the right to maintain dignity, personal autonomy, and freedom when voluntarily seeking medical care. There should not be discrimination based on a psychiatric complaint or diagnosis. It is discrimination when no other patients seeking out ER care are held behind, or restricted from a choice to leave by having to request being released from behind, locked doors. It is inherently traumatic and dehumanizing for any person to have their freedom taken away through the use of locked doors or the perception of being treated like a criminal. There is no legal basis for involuntary detention of anyone who is not in the custody of the state. Such detention of persons with a mental health disability is clearly discrimination under the Americans with Disabilities Act. As recently noted by a District Court ruling in Mississippi (Case 3:16-cv-00622-CWR-FKB Document 234 Filed 09/03/19), the Supreme Court has found that violations of the ADA include situations where in order to receive medical services, persons with mental disabilities must relinquish rights while *"persons without mental disabilities can receive the medical services they need without similar sacrifice."* That is precisely what occurs if a person seeking emergency room care in a psychiatric crisis is required to forego personal freedom in order to receive treatment.

There are a minority of patients presenting at the ED who may require a secure, locked area because they are in the legal custody of law enforcement or of the Department of Mental Health and who also have significant safety needs. However, according to DMH data, **individuals in state custody represent only 10 percent of inpatient psychiatric admissions in the state, and they represent only 20 percent of bed days among patients waiting in EDs for availability of an inpatient bed.**

Beyond the legal issues, the perceived need for a locked area, and its existence, for mental health patients reinforces stigma among the public and staff regarding psychiatric diagnoses and fear of individuals with those labels. These fears are based on experiences with a tiny minority of people, yet design is occurring to address that minority, to the exclusion of appropriate response to all others. Stigma is known to be the primary obstacle to people seeking mental health care, and the use of locked spaces exacerbates that obstacle. Being placed in a locked psychiatric suite reinforces shame and loss of dignity; creates a perception of being punished for having a mental health crisis; imposes a stigma of "presumed non-compliance" despite seeking help; reinforces fears about being held involuntarily if feelings are fully disclosed; places MH patients in the same frightening environment that other ER patients are being protected from through the segregation of those patients who are disruptive or aggressive; creates risk that individuals will avoid or delay seeking help because of fear of being stigmatized or held involuntarily with potentially fatal consequences; and violates the principles of trauma-informed and person-centered care. [1]

CMS Standards

Finally, to the extent that the application implies that its proposed ED design for psychiatric care is necessary to meet CMS requirements, it is clear that this is not true. While CMS requires a safe environment of care (and note, it defines "safe" as including respect and dignity as part of emotional safety)[2] it does not specify the means, and it in no way suggests that a locked area is the appropriate means to create safety. NMC's CMS violations were based on inappropriate use of law enforcement for health care functions (analogous, we think, to our observation that a locked area creates a perception of being imprisoned for wrongdoing rather than being treated for a health condition.) Safety for a mental health crisis should include precautions against self-harm and access to personal supports for the individual, including, at times, the need for continuous one-to-one support which is often most appropriately provided by a peer support staff person. Such measures can fully meet safety needs without violating the right against discrimination. In the situations where a person is in state custody and is not permitted to leave, there may be a need for a more secure setting if the patient is at individualized assessed risk of attempting to leave, or of highly dysregulated behavior. To the extent NMC uses such an individualized assessment for persons in legal DMH custody and that it meets the statutory standard of the "least restrictive means" to maintain safety, use of a locked area may be authorized. (See 18 VSA § 7508, regarding patients in the custody of the Commissioner and use by hospitals of "the least restrictive manner necessary to protect the safety of both the person and the public.") We re-emphasize, however, that individuals in state custody represent only 20 percent of bed days of ED use, and among these individuals, many are not aggressive or at risk of absconding.

In addition, though there has been a great deal of regulatory focus in the recent past on prevention of self-harm, specifically suicide, in hospitals, based on long-standing data portraying this as a major failure of health care safety, that data has recently been completely debunked in a report by the Joint Commission. In its reported first data-driven review, it stated, "The estimated range of 48.5 to 64.9 inpatient suicides per year is vastly lower than the most widely quoted figure of 1,500 per year, which appears to have been based on speculation. www.jointcommissionjournal.com/article/S1553-7250(18)30253-8/fulltext The article went on to say that actual data on the types of suicide that do occur in hospitals "support the recommendations from a recent Joint Commission Technical Expert Panel that psychiatric hospitals and inpatient psychiatric units in general medical/surgical hospitals should be made "ligature-resistant" environments to decrease the risk of suicide by hanging … prevention recommendations have focused on conducting risk assessments, improving the safety of the environment (for example, removing ligature points), and implementing risk mitigation strategies (for

example, protective observation policies and procedures)." **Notably absent from the report is any recommendation to lock patients up in emergency rooms.**

We question the NMC response that CMS has "specified" the RRMC design as "best practice," because CMS establishes regulatory standards (aligned with the Joint Commission, with its standards as cited above) but does not identify "best practice" designs. It finds hospitals in compliance with standards or not, but a finding that RRMC is in compliance simply means it does not violate any CMS standards; it does not indicate that any of its practices or design are best practice, nor does it address the ADA or state statutory requirements. The avoidance of access to ligature points in the RRMC design and the ability to include protective observation are certainly best practice and follow CMS guidance. There is no evidence of a "best practice" that permits voluntary patients to be locked up. To the contrary, CMS recently published proposed new standards for psychiatric patient safety which are almost exclusively focused on ligature dangers. **It references standards when applied to either locked or unlocked emergency department psychiatric rooms, with absolutely no suggestion that locked areas represent a requirement or a best practice.** www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO-19-12-Hospitals.pdf (April 19, 2019) (Attached.)

Conclusion

We believe that any CON issued for the NMC ED renovation, in order to meet CON criteria for equal access to quality care, needs to include conditions requiring a redesign of the designated mental health suite in alignment with these comments.

These include, first, that the area create access to a common space for patients within the sub-suite, including adequacy for peer and family visits as required by statute.

Second, it needs to operate as a subsection of the ED that is not segregated by locked doors and does not lock patients in, except for the capacity to have a secure portion that is utilized solely for patients under the legal custody of the state and only when it meets the least restrictive means for safety as required under state law. The Green Mountain Care Board should not approve design of an area that might subject patients to dehumanizing and discriminatory practices, and should therefore require that any capacity to lock up patients be conditioned upon a prohibition on use with voluntary, self-referred patients.

Sincerely,
/s/

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[1] A study published online in August reported finding that nearly half of all patients withhold critical information about their mental health out of embarrassment and fear both of stigmatization and the possible long-term implications of sharing such information. *"These findings suggest that concerns about potential negative repercussions may lead many patients who experience imminent threats to avoid disclosing this information to their clinician."* Assessment of Patient Nondisclosures to Clinicians of Experiencing Imminent Threats, *JAMA Netw Open.* 2019;2(8):e199277.

[2] "The CMS hospital Condition of Participation, "Patient's Rights" (42 C.F.R. §482.13(c)(2)) establishes the rights of all patients to receive care in a safe setting and is intended to provide protection for a patient's emotional health and safety as well as his or her physical safety. Respect, dignity, and comfort are also components of an emotionally safe environment." www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO-19-12-Hospitals.pdf